CITY OF SAN ANTONIO EMPLOYEE BENEFIT GUIDE

BENEFIT *Matters*

It's Your Choice

INSIDE THIS EDITION

- 2017 Premiums
- Health Plans
- Helpful Tools

210.207.8705

RETIREE

www.sanantonio.gov/employeeinformation/retiredemployees

Quick Look

- The Consumer Choice and New Value medical plan options will continue to be offered to retirees in 2017. There are no changes to these health plan options. More information is available on pages 3 - 5.

HIGHLIGHTS FOR 2017:

NEW • Blue Cross and Blue Shield of Texas and CVS/caremark will serve as the third-party administrators who process our medical and pharmacy claims.

- For retirees enrolled in Consumer Choice, HSA Bank will be the administrator for your Health Savings Account.
- Your monthly premiums for vision coverage have decreased from last year.

• Your current tobacco use status will continue in 2017. Tobacco users will be assessed a $40 monthly fee. Learn how you can stop the fee on page 7.

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ICON LEGEND

Important Information Up Ahead

Money-Saving Opportunity

NEW New Information

Good News

Non-Medicare Retirees

In 2017, non-Medicare retirees will have the option of selecting either the Consumer Choice or New Value medical plan option.

Medical Plans At-A-Glance

Here is a side-by-side comparison of the two medical plan options available to you in 2017. As you can see in the chart below, both medical plan options cover the same health care services. However, the amount you pay out-of-pocket will vary between options.

Plan Benefit	Consumer Choice		New Value PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
City Contribution to Health Savings Account (Retiree Only / Family)	$500 / $1,000 Health Savings Accounts are funded by City and retiree contributions. They are medical savings accounts.		N / A	
Preventive Care	100%	60% after deductible	100%	60% after deductible
Annual Deductible (Retiree Only / Family)	$1,300 / $2,600	$2,600 / $5,200	$1,250 / $2,500	$2,500 / $5,000
Annual Out-of-Pocket Maximum (Retiree Only / Family)	$4,000 / $8,000*	$8,000 / $16,000	$3,000 / $6,000	$6,000 / $12,000
Co-insurance (After Deductible)	80% / 20%	60% / 40%	80% / 20%	60% / 40%
Office Visit Co-pays: Primary Care / Specialist / Urgent Care	20% after deductible	40% after deductible	$30 / $55 / $50	40% after deductible
Emergency Care and Ambulance Services	20% after deductible			
In-Patient Hospital Admissions, Out-Patient Surgery, Durable Medical Supplies, and Radiology	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Physical, Occupational, & Speech Therapy	20% after deductible	40% after deductible	20% after deductible	40% after deductible

*For family coverage, one family member could pay as much as $7,150 in 2017.

Non-Medicare Retiree Premiums

Retiree premiums comprise a portion of the actual cost of the retiree medical plan. The City pays approximately 67% of the cost for retiree medical coverage. In order to maintain your coverage, it is critical that you pay your premiums promptly. Any retiree with a past due account of more than 60 days will be subject to termination of medical coverage with no opportunity for re-enrollment into the plan. Retirees participating in the City's non-Medicare medical plans are required to pay for their coverage using an automated bank draft.

Non-Medicare Monthly Premium Rates

The table below features the monthly premium amounts for non-Medicare retirees based upon your length of service at the time of your retirement. Included in this table is the amount the City contributes toward the cost of each option. For example, if you select the Consumer Choice plan, are in the Retiree Only category, and had 30+ years of service, you pay $204 monthly and the City pays $537.96 monthly to cover the total cost of the monthly premium.

2017 Monthly Non-Medicare Premiums								
Hired Before 10/1/2007								
Years of Service	30+		25-29		20-24		19 & Under	
Consumer Choice PPO								
	Retiree	City	Retiree	City	Retiree	City	Retiree	City
Retiree Only	$204	$537.96	$222	$519.96	$241	$500.96	$303	$438.96
Retiree + 1	$409	$979.67	$429	$959.67	$474	$914.67	$631	$757.67
Retiree + 2 or More	$583	$1,289.23	$617	$1,255.23	$682	$1,190.23	$911	$961.23
New Value PPO								
Retiree Only	$277	$908.78	$306	$879.78	$331	$854.78	$401	$784.78
Retiree + 1	$522	$1,697.35	$561	$1,658.35	$617	$1,602.35	$778	$1,441.35
Retiree + 2 or More	$724	$2,268.17	$780	$2,212.17	$860	$2,132.17	$1,088	$1,904.17

Hired On or After 10/1/2007				
Years of Service	10+		5-9	
Consumer Choice PPO				
	Retiree	City	Retiree	City
Retiree Only	$370	$371.96	$741.96	$0
Retiree + 1	$694	$694.67	$1,388.67	$0
Retiree + 2 or More	$936	$936.23	$1,872.23	$0
New Value PPO				
Retiree Only	$592	$593.78	$1,185.78	$0
Retiree + 1	$1,109	$1,110.35	$2,219.35	$0
Retiree + 2 or More	$1,496	$1,496.17	$2,992.17	$0

Note: The monthly premium amounts do not include the $40 monthly tobacco surcharge.

Two Medical Plans - Choose The One That Is Best For You

Of the two non-Medicare medical plan options, Consumer Choice is the only Consumer-Driven Health Plan (CDHP). As you will recall, a CDHP allows you to have more control over how your health care dollars are spent. Here are some key elements of Consumer Choice that make it different from New Value.

Consumer Choice and New Value - How Are They Different?

Plan Feature	Consumer Choice (CDHP) PPO	New Value PPO
Health Savings Account (HSA)	Allows you to pay for qualified health care out-of-pocket expenses or save for future expenses with money that is yours to keep and that carries over from year to year. City contributes $500 for a retiree-only plan and $1,000 for a family plan. To be eligible for an HSA, you have to be enrolled in Consumer Choice, not covered by another medical plan (ex: Medicare, Tricare, etc.), and not claimed as a dependent on someone else's federal tax return.	Does not apply.
Co-pays	Does not apply.	Co-pays apply in the amounts of $30, $50, and $55 based on the type of provider you select.
Family Deductible	The family deductible can be met by one family member or a combination of family members. For example, for a family of five, the family's $2,600 deductible can be met by one family member or a combination of any of the five family members. The maximum out-of-pocket to be paid by any one individual on the plan will not exceed $7,150 in 2017.	A family would need at least two people to meet the individual deductible in order to meet the family deductible. For example, two family members would need to reach $1,250 each in health care expenses in order to meet the $2,500 family deductible.
Out-of-Pocket Maximum	Your out-of-pocket maximum includes your deductible and co-insurance. For 2017, an individual on a family plan cannot exceed $7,150 in out-of-pocket costs.	Your out-of-pocket maximum includes your co-pays, deductible and co-insurance. The maximum out-of-pocket to be paid by one individual on the plan will not exceed $3,000.
Prescription Drug Coverage	You are responsible for 100% of the discounted cost of your prescription medications (from in-network providers) until you meet your deductible. For IRS-approved maintenance medications, such as those used to manage high blood pressure, diabetes, osteoporosis, and cholesterol, you only pay 20% of their cost since they are not subject to the deductible.	Co-pays apply in the amounts of $10, $35, $65, and $100 based on the tier of medication you need. For those managing diabetes through medication, the City's Value-Based Co-pay Program offers $0 co-pays for Tier 1 medications, $10 for Tier 2, and $20 for Tier 3.

Tools & Resources for Non-Medicare Retirees

Tool	What it provides	Where to find it
Blue Access for Members (BAM) website	This website gives you 24/7 access to information about your medical benefits. You can check the status of a claim, locate in-network doctors or providers, print temporary I.D. cards, and more.	bcbstx.com/member (click the login tab and register)
CVS/caremark Member Services website	This website allows you to order refills, check drug cost and coverage, enroll in mail order, find in-network pharmacies, and more.	caremark.com

Non-Medicare Prescription Drug Plan

When considering your retiree health plan options, it is important to consider your prescription needs. The City's prescription drug benefit, which is administered by CVS/caremark, provides you with access to a wide variety of medications, while helping to make the ones you need more affordable. You also have access to a large group of in-network pharmacies, including CVS, Walgreens, and H-E-B, to fill your next prescription. To locate an in-network pharmacy near you, call CVS/caremark Customer Service at 866-808-7470.

With the 2017 prescription drug plan, four pricing tiers, reduced co-pays for prescription medications related to diabetes, and coverage for several popular tobacco cessation medications will continue to be offered. Also, the prescription drug plan will help you manage your pharmacy costs by encouraging the use of generic equivalents, when available.

Automatic Generics Program

This program automatically provides you with a generic equivalent to your prescription medication, when available. You do not even have to ask for it. Generic prescription drugs, which are mostly found in Tier 1, contain the same active ingredients as brand name drugs typically found in Tiers 2 and 3. The majority of brand name drugs have an available generic equivalent. You still have the option of purchasing brand name prescription drugs; however, you will pay the difference between the generic cost and the brand name co-pay. If your doctor requires that you only take brand name medications, make sure your prescription indicates "dispense as written." With "dispense as written" on your prescription, you will only pay the applicable co-pay for the brand name medication.

Value-Based Co-pays

It is important for retirees and their dependents with diabetes to follow their prescription drug regimen to effectively manage their health. To continue assisting retirees and their eligible dependents who have diabetes with achieving a better quality of life, the City's Value-Based Co-pay plan offers prescription drugs related to diabetes at a reduced co-pay amount, including $0 co-pays on Tier 1 medications.

2017 Prescription Drug Plan		
	Prescription Co-pays	Value-Based Co-pays
30-day Retail		
Tier 1	$10	$0
Tier 2	$35	$10
Tier 3	$65	$20
Tier 4	$100	N / A
90-day or Mail Order		
Tier 1	$20	$0
Tier 2	$70	$20
Tier 3	$130	$40

90-day Mail Order Prescriptions

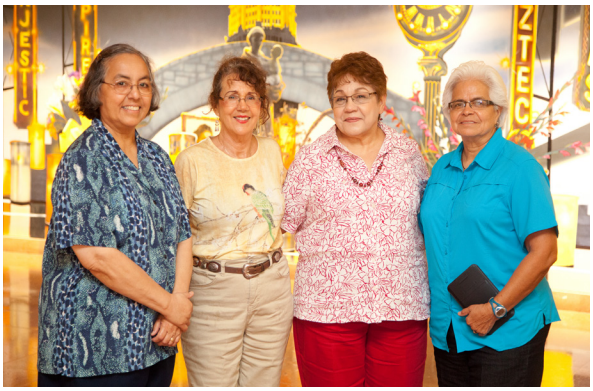
Purchasing a 90-day supply of your prescription drugs is convenient and saves you money on the maintenance medications you take every day. The best part is you can have a 90-day supply of your medication delivered to you at home through the Mail Order Pharmacy Program.

Not only will you save yourself from having to wait in line at the pharmacy, but ordering your medications through the Mail Order Pharmacy Program is the best way to ensure that your 90-day supply is available when you need it. To begin using mail order, visit sanantonio.gov/employeeinformation.

Prescriptions and Consumer Choice

Remember, Consumer Choice does not have co-pays. You are responsible for 100% of the discounted cost of your prescription medications until you reach your deductible. For IRS-approved maintenance drugs, like those used to control high blood pressure, cholesterol, and diabetes, you only pay 20% of their cost since they are not subject to the deductible.

A complete list of IRS-approved maintenance medications can be found online, under the prescription drugs tab, at sanantonio.gov/employeeinformation/retiredemployees/nonmedicarebenefits.



Retiree Brown Bag Sessions

The City will continue to offer the Retiree Brown Bag Sessions in 2017. Through these sessions, you will continue to have the opportunity to learn more about topics including health care, fitness, mental wellness, and stress management. Remember, the Retiree Brown Bag Sessions are open and FREE to all City of San Antonio retirees and their spouses or domestic partners.

For more information about the Retiree Brown Bag Sessions, contact Human Resources Customer Service at 210-207-8705 or hrcustomerservice@sanantonio.gov.

Tobacco Use

Introduced in 2013, the City's $40 monthly tobacco surcharge for those non-Medicare retirees who use tobacco and are enrolled in a City medical plan will continue. The surcharge is in addition to the monthly medical premium. Your current tobacco use status will automatically roll over to 2017.

Remember, the City defines a "tobacco user" as a person who has used tobacco products within the past 60 days. Tobacco products include, but are not limited to: cigarettes, cigars, pipes, all forms of smokeless tobacco (chewing tobacco, snuff, dip, or any other product that contains tobacco), clove cigarettes, or any other smoking devices that use tobacco such as hookahs. Electronic and smoke-free cigarettes are also included in the definition of a tobacco product.

Tobacco Cessation Resources

The City's prescription drug plan covers several popular tobacco cessation prescription medications. These medications include, Buproban, which is a Tier 1 prescription medication, and Chantix, Nicotrol, and Zyban, which are Tier 3 prescription medications. Additionally, a resource for those seeking to quit tobacco is the American Cancer Society's Texas Tobacco Quitline, 877-YESQUIT (937-7848), and their website, quitnow.net/texas.

I Quit, So What is Next?

You can stop the $40 monthly surcharge by completing a tobacco cessation program and remaining tobacco-free for 60 consecutive days. Once you have done both of these things, you should contact the Employee Benefits Office at 210-207-0073 to submit a new Tobacco Declaration Form certifying that you no longer use tobacco and a certificate of completion from your tobacco cessation program. The system will be updated to reflect your new status and your monthly premium payment will be adjusted within four to six weeks from the time you submit your documentation.

Note: You will not be refunded for any amount you have paid in monthly fees prior to the new Tobacco Declaration Form being processed.

Retiree Dental Plan

Because regular dental visits are a key part of maintaining your overall health, the City offers you access to dental insurance through Delta Dental.

Through the dental benefits plan administered by Delta Dental, you have access to a network of dental providers who can help you meet your oral health goals.

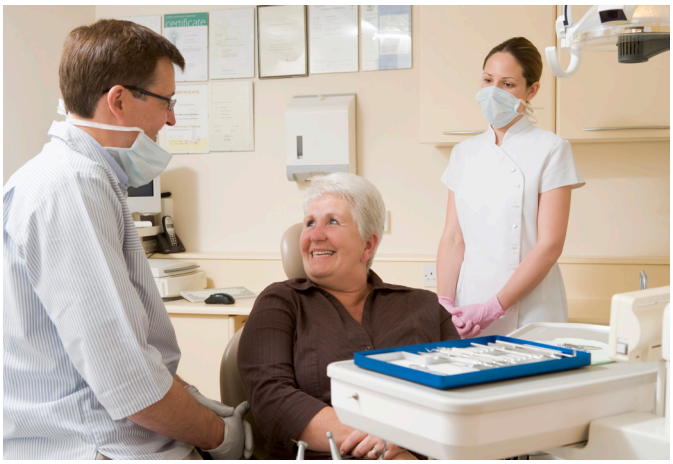
DeltaCare Dental HMO

The DeltaCare Dental HMO is a dental plan that provides comprehensive dental care when services are obtained from an in-network primary dentist. DeltaCare enrollment packets, with participating providers, are mailed to eligible retirees every annually. If this is your first time enrolling in the retiree dental care plan, you will need to select a participating dentist from the DeltaCare network of providers to serve as your primary dentist. The dentist should be within a 35-mile radius of your zip code.

With this plan, you are only responsible for the co-pays for any covered services you receive from your selected dentist. There are no deductibles, yearly maximums, or paperwork to file. Examples of common services and co-pays are featured in the chart below.

Monthly Premiums

Dental Plan	DeltaCare DHMO
Retiree Only	$13.66
Retiree + Spouse / Domestic Partner	$25.45
Retiree + Child(ren)	$25.45
Retiree + Family	$38.19



Description	Procedure Code	Co-pay
Office Visit	D0999	$5
Oral Exam, X-rays, and Fluoride Treatment*	N / A	No Co-pay
Prophylaxis (Teeth Cleaning Twice a Year)	D1110	No Co-pay
Periodontal Scaling and Root Planning, Per Quadrant	D4341	$40
Amalgam Fillings for One Surface, Anterior	D2140	$5
Surgical Extraction and Erupted Tooth	D7210	$45
Root Canal-Endodontic Therapy, molar (excluding final restoration)	D3330	$280
Crown	D2750	$295
Orthodontics (Children and Adults)	D8070 (children) / D8090 (adults)	$1,700 / $1,900

*Note: Fluroide Treatment is specific for children up to age 19.

Retiree Vision Plan

Healthy eyes and clear vision are an important part of your overall health and quality of life. Through Davis Vision, you have access to a national network of doctors and retail providers. Eye exams, eyeglasses, and contacts are available to you at only the cost of applicable co-pays.

Davis Vision Collection

To maximize your vision plan benefit, consider purchasing frames or contact lenses from The Davis Vision Collection. The Collection is available at a number of independent provider locations. Independent providers do not include retail stores such as Visionworks or Walmart. To locate a participating independent provider near you, visit DavisVision.com.

Frame Benefits

Several designer and brand name frames are available to you at only the cost of the applicable co-pays through Davis Vision's Frame Collection. For frames outside of the Davis Vision Frame Collection, you are allowed a $130 retail allowance. NEW In 2017, when you shop at a Visionworks store, you will receive a $155 retail allowance toward any frame.

Contacts Benefits

Contact lenses selected from Davis Vision's Contact Lens Collection are covered in full. You are allowed a $150 retail allowance toward contacts outside of the Davis Vision Contact Lens Collection.

Additional Vision Benefits

You also have access to additional discounts on popular lens options and coatings such as scratch-resistant coating, polycarbonate lenses, and standard progressives (no-line bifocal).

Through Davis Vision's Eye Health Connection Program, individuals with cataracts, diabetes, macular degeneration, and glaucoma are eligible to receive an additional eye exam during the calendar year.

Visit DavisVision.com for more information about the additional vision benefits available to you.

Out-of-Network Benefits

You have the option of receiving services from an out-of-network provider. When receiving these services, you must pay the provider directly for all charges and then submit a claim form for reimbursement to: Vision Care Processing Unit, P.O. Box 1525 Latham, NY 12110. The reimbursement form can be found online at sanantonio.gov/employeeinformation/benefits/resources.

Vision Plan	Monthly Premium
Retiree Only	$9.75
Retiree + 1	$17.41
Retiree + 2 or more	$25.80

In-Network Benefit Summary

Comprehensive Eye Exam - $10 co-pay, one exam per year	
Frames (in lieu of contacts)	Contacts (in lieu of eyeglasses)
Once per calendar year beginning January 1.	Once per calendar year beginning January 1.
$130 retail allowance toward any frame from provider, plus 20% off balance[3].	$150 retail allowance toward Non Collection Contact lenses, plus 15% off balance[1].
OR	OR
Visionworks Allowance: $155 retail allowance toward any frame from a Visionworks provider, plus 20% off balance.	Any contact lenses from Davis Vision's Contact Lens Collection[2].
OR	
Any fashion or designer frame from Davis Vision's Collection[1] (value up to $195).	Contact Lens Evaluation, Fitting & Follow-Up Care: Once per calendar year beginning January 1. Davis Collection contact lens covered in full, including fitting fee. Fitting fee is an additional charge minus 15% discount if Non Collection contact lens[2].
One year eyeglass breakage warranty included at no additional cost.	
Spectacle Lenses - Once per calendar year beginning January 1. For standard single-vision, lined bifocal, or trifocal lenses.	

1. For dependent children, monocular patients, and patients with prescriptions of 6.00 diopters or greater.

2. Davis Vision Collection is not available at retail providers. It is only available at participating independent provider locations.

3. Additional discounts not applicable at Walmart or Sam's Club locations.

Eligibility for Retirees / Dependents

City of San Antonio employees who leave the City with at least 20 years of service or have five years of service and are 60 years of age are eligible for City of San Antonio retiree medical benefits.

Retirees who meet eligibility requirements for retiree medical benefits must enroll in a City retiree medical plan or waive coverage within 31 days from the date of separation from service.

Waiving Medical Coverage

Retirees also have the option of waiving the City's medical coverage; however, you must do so at the time that you separate from the City. Retirees who choose to waive coverage are allowed one opportunity to re-enter the City's medical plan at a later date, as long as they provide proof of continuous medical insurance coverage.

The continuous coverage can be a spouse's, employer's, or individual plan and enrollment must be requested within 31 days of the loss of that coverage. Those who do not enroll in the City's medical plan at the time of separation and do not elect to waive coverage will not be allowed to enroll in the City's medical plan at any time. If you enroll in the City's medical coverage and then request to cancel that coverage, you will not be allowed to re-enroll in the City's medical plan.

Eligible Dependents

Dependents may be enrolled in City retiree medical benefits if they were covered at the time of your retirement and you enroll them at the time of your initial retiree medical election. Dependents who continue to meet eligibility requirements will remain on the plan until you remove them, cease to make the required contribution, or the dependent no longer meets the eligibility criteria. Once a dependent is removed, the dependent cannot be added back onto the medical plan.

Retirees who waived coverage at the time of separation but are eligible to re-enter the City's medical plan, may only enroll those dependents who were covered at the time coverage was waived. Dependents must return to the plan along with the retiree; they will not be added to the plan at a later date.

Making Changes During the Year

There are certain life events that can happen during the year that will allow you to change the level of coverage (retiree only, retiree plus one, or retiree plus 2 or more) for your medical plan.

Those life events are:

Divorce, Annulment, Dissolution of a Domestic Partnership and Death of a dependent.

You must notify the Employee Benefits Office within 31 calendar days of your life event and provide all required documentation in order for the changes in your coverage to take effect during the calendar year. If you fail to notify the Employee Benefits Office within 31 calendar days, you forfeit any past premium refund.

Glossary of Common Health Care Terms

The following is a list of health care terms that are used throughout this benefit guide. We have provided explanations for each of them so that you may better understand your benefits, how they work, and what choices will be best for you and your dependents.

Consumer-Driven Health Plan (Consumer Choice)

Consumer-Driven Health Plan (CDHP) - A type of insurance plan in which you are responsible for most of the cost of your health care expenses until the plan's deductible and out-of-pocket maximum are reached. This type of plan has lower premiums than the other two health plans, but higher deductibles and out-of-pocket maximums.

Health Plan Features

Annual deductible - The amount you need to pay, not including co-pays, for covered health care services before the health plan pays. The annual deductible counts toward your out-of-pocket maximum.

Co-insurance - The percentage you have to pay for health care services after you have met your annual deductible. Co-insurance amounts count toward your out-of-pocket maximum.

Co-pay - The flat fee you pay for certain services like doctor's, specialist's, or urgent care office visits or prescription drugs. Prescription drug and office visit co-pays count toward your out-of-pocket maximum.

Health Savings Account (HSA) - A tax-exempt savings account that can be used to help pay for current and future qualified medical expenses. You can only have an HSA if you are enrolled in a Consumer-Driven Health Plan like Consumer Choice.

Out-of-pocket maximum - The most you will pay for covered health care services in a calendar year. Once you reach it, the health care plan pays 100% of the cost of covered health care services for the remainder of the year. All covered health care expenses count toward the out-of-pocket maximum, except for premiums.

Prescription Drugs

Tier 1 (Generic) drugs - Medications that generally cost the least. They usually include the generic equivalents of brand name drugs.

Tier 2 (Preferred brand formulary) drugs - Medications that are typically your mid-range-cost option. Consider a Tier 2 drug if no Tier 1 medication is appropriate to treat your condition.

Tier 3 (Non-preferred brand) drugs - Medications that often include brand name drugs without generic versions or brand name drugs that are new to the market.

Tier 4 (Specialty) drugs - Medications that require special handling, administration, or monitoring. These drugs are often used to treat chronic illnesses such as cancer, hemophilia, multiple sclerosis, and Crohn's disease.

Provider Networks

In-network - A group of approved doctors, hospitals, and other health care professionals that provide quality care at contracted rates. These providers must pass a rigorous review of their personal history, disciplinary actions, licenses and certifications, and relevant training and experience.

Out-of-network - Doctors, hospitals, or other health care professionals that are not in the health plans' network. Service from these providers will, in many cases, cost you more than the same service from an in-network health care provider.

Types of Office Visits (Co-Pays)

Primary Care - A visit to a physician, nurse practitioner, clinical nurse specialist, or physician assistant who provides, coordinates, or helps you access a range of health care services.

Specialist - A visit to a physician specialist who focuses on a specific area of medicine to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Urgent Care - A visit to an urgent care facility to receive treatment for an illness, injury, or condition serious enough to seek care right away, but not so sever as to require a trip to the emergency room.

Notes

Contacts

Organization	Phone	Website
San Antonio Human Resources Department	210-207-8705	sanantonio.gov/employeeinformation/retiredemployees hrcustomerservice@sanantonio.gov cosaretiree@sanantonio.gov
Retiree Ombudsman - Ann Solis	210-207-0073	ann.solis@sanantonio.gov
CVS/caremark (Pharmacy Claims Administrator)	866-808-7470	caremark.com
Davis Vision (Vision Provider)	800-448-9372	davisvision.com
DeltaCare DHMO (Dental Plan)	800-422-4234	deltadentalins.com/cityofsanantonio/retirees.html
ICMA Retirement Corporation	800-669-7400	icmarc.org
Nationwide Retirement Solutions	877-677-3678	nrsforu.com
San Antonio Fire & Police Pension	210-534-3262	safppf.org
Social Security Administration	800-772-1213	socialsecurity.gov
Texas Municipal Retirement System	800-924-8677	tmrs.com
Blue Cross and Blue Shield of Texas	800-521-2227	bcbstx.com
HSA Bank (Health Savings Account Customer Service)	855-731-5220	hsabank.com

Health Benefits Notices

The City of San Antonio makes every effort to communicate regularly with retirees. Our primary method of communication is through Retiree Matters, the City's newsletter for retirees. It is produced quarterly and at other times when we need to share information. Retiree Matters is mailed to your home address. Please make sure the City has your correct address at all times. If you change your address, email Human Resources Customer Service at cosaretiree@sanantonio.gov to update your information.

We also encourage you to visit the retiree website at SanAntonio.gov/employeeinformation/retiredemployees. Refer to it to learn more about your retiree medical benefits and for complete information on each of the notices referenced below.

City Retiree Medical Benefit Program Design and Funding

Any benefits and contributions under the City of San Antonio's insurance or self-funded programs are subject to change as determined by the City Council in any budget year, or by ordinance or amendment.

The City Manager, or her Designee, may be authorized to amend the City retiree medical benefits plan and set premiums for retiree and dependent coverage, so long as sufficient funds are appropriated by City Council (see ordinance #2016-09-15-0694).

Creditable Coverage

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please visit sanantonio.gov/employeeinformation/retiredemployees.aspx.

Notice of Privacy Practices

The City of San Antonio takes the privacy and security of your confidential health information seriously. Health information about you is protected and will be shared only with other covered entities for treatment, payment, and health care operation activities. Additionally, you have the right to obtain copies of your health record (medical claims and enrollment records), request a correction, restrict communications, request a copy of our Privacy Practices Policy, authorize someone to represent you or file a complaint if you believe your privacy rights have been violated. For detailed information regarding the City of San Antonio Privacy Policy, please visit sanantonio.gov/Portals/0/Files/EmployeeInformation/Benefits/privacy.pdf.

Summary Plan Documents/Plan Documents

This guide is intended to provide summary information about the benefit plans offered to retirees of the City of San Antonio. Complete plan details are available in the Summary Plan Documents for the Consumer Choice and New Value PPO plans and can be obtained from the Human Resources Department. In the event of a discrepancy between this document and the official Summary Plan Document/Plan Document, the Plan Documents shall govern.

Women's Health Act

The Women's Health and Cancer Rights Act of 1998 requires that all health insurance plans that cover mastectomy also cover the following medical care:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedemas and mastectomy bras and external prostheses limited to the lowest cost alternative that meets the patient's physical needs.

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